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M E M O R A N D U M

TO: All Members

FROM: Patrick Cucinelli, Senior Director of Public Policy Solutions

DATE: January 10, 2013

SUBJECT: **Fiscal Cliff and Important Medicare Changes for 2013**

ROUTE TO: Administrator, CFO

Abstract: Fiscal Cliff legislation and other Medicare changes directly impact health care providers with the start of 2013.

Introduction

The House voted 257-167 for the passage of H.R. 8: American Taxpayer Relief Act of 2012, which the Senate had passed earlier by a vote of 89 to 8 and the bill was signed by the President. The so-called "fiscal cliff" agreement had been negotiated between Senate Minority Leader Mitch McConnell (R-KY) and Vice President Joe Biden.

The legislation keeps the Bush era tax cuts for individuals making less than $400,000 and couples making less than $450,000. It also makes permanent the fixes for the Alternative Minimum Tax and delays government spending cuts for two months. Along with delaying any potential cuts to Medicare, the agreement extends the current Medicare Part B rates for one year, the so-called “Doc Fix,” averting what would otherwise have been a 26.5 percent reduction in these payments. The bill imposes some new limits on tax deductions for charitable contributions, a provision that we have been strongly opposing.

Following are the provisions from the agreement and other important Medicare changes health care providers need to be aware of for the start of 2013.

No Cuts to Medicare

There are no additional Medicare cuts to skilled nursing facilities, home health or hospice providers. The bill focused on hospitals for payment reductions to pay for the "doc fix" (see below). However, there remains concern over potential cuts that could in the future apply to long-term care providers, especially recoupment for up-coding. The 2% across-the-board spending reduction mandated by the Budget Control Act of 2011 was suspended for 2 months.

Medicare Part B and the "Doc Fix"

The legislation delays for one year a planned cut in Medicare payments for physicians and other Medicare Part B providers. Medicare Part B payments are determined in part by the sustainable growth rate (SGR). The SGR was established by law in 1997 and is designed to limit the annual increase in physician payments to the annual increase in the U.S. gross domestic product (GDP). Each year, CMS announces a conversion factor that adjusts Part B payments relative to the change in GDP. Since 2002, Congress has intervened to ensure that payments increase or stay even despite actual reductions called for by the SGR. Over time the gap between actual payments and the SGR formula has compounded so that the gap becomes exponentially larger each year. Congress has mandated an alternative to the SGR, also known as the "doc fix", but to date CMS has failed to develop a new methodology.

The announced spending cut under the SGR for Medicare Part B payments was 26.5 percent for 2013 (77 FR 68891). Under this legislation, the conversion factor is set at zero, which means that physician Medicare payments will remain relatively unchanged for 2013. The extension of existing Medicare physician payments will cost about $25 billion over 10 years, according to the Congressional Budget Office.

- ***Therapy Caps***

The therapy caps and the exceptions process continues in 2013. The new financial limits are $1,900 for occupational therapy (OT) and $1,900 for physical therapy (PT) and speech language pathology (SLP) combined. Because therapy caps are determined for a beneficiary on a calendar year basis (January 1st through December 31st), all beneficiaries began a new cap for outpatient therapy services received on January 1, 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used. Therapists may request an automatic exception for claims that are between $1,900 and $3,700 in expenditures. Changes from last year that we assume will continue this year include:

1. Applying the Therapy Caps to hospital outpatient settings. The new law expands the cap to therapy services furnished in a hospital outpatient department (OPD). This was done to prevent a shift in the site of service to higher cost settings once a patient hits their financial limit. More information about the changes affecting hospital OPDs will become available in the future.

2. A mandate that Medicare perform manual medical review of therapy services furnished began on October 1, 2012, if outpatient therapy service to a beneficiary has reached the dollar aggregate threshold amount of $3,700, including therapy services furnished in hospital OPD. The manual medical review exceptions process applies to patients who meet or exceed $3,700 in therapy expenditures for PT/SLP combined and a separate $3,700 in OT expenditures.

3. All claims for therapy services furnished on or after October 1, 2012, include the National Provider Identifier of the physician who reviews the therapy plan.

4. Providers of outpatient therapy services, including SNFs, are required to continue to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2013.

Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub. 10004, Chapter 5, Section 10.3.

- ***New Therapy G-Codes***

Effective January 1, 2013, CMS is implementing a claims-based data collection system that includes: (1) the reporting of data by therapy providers and practitioners furnishing therapy services, and (2) the collection of data by the contractors. This reporting and collection system requires claims for therapy services to include nonpayable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at:

- The outset of the therapy episode of care,
- Specified points during treatment, and
- The time of discharge.

These G-codes and related modifiers are required on specified claims for outpatient therapy services, not just those that exceed the therapy caps. A testing period will be in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements in order to assure that their systems work. During this time period claims without G-codes and modifiers will be processed.

In order to implement use of these G-codes for reporting function data on January 1, 2013, a new status indicator of "Q" has been created for the Medicare Physician Fee Schedule Database (MPFSDB). This new status indicator will identify codes being used exclusively for functional reporting of therapy services.

For complete details please refer to Medlearn Matters # MM8005.

- ***Elimination of Improvement Standard***

Members are reminded that we are still waiting for CMS to revise the provider manual in response to the settlement in the case of Jimmo v. Sebelius. This case centers on the "Improvement Standard" in Medicare that requires that an individual show improvement in his or her condition or functional status in order to qualify for Medicare coverage of therapy services. The plaintiff in this case alleged that this standard wrongfully denies Medicare coverage to patients suffering from chronic conditions and who are in need of skilled nursing facility (SNF) care and home health (HH) care, as well as outpatient therapy (OPT).

To settle the case, CMS agreed to revise the Medicare Benefit Policy Manual and the Internet Only Manual 100-02 to "clarify" the coverage standards to include SNF, HH and OPT benefits when a patient has no restoration or improvement potential but when that patient needs SNF, HH or OPT services. Understanding the full extent to which this case will impact the provision of therapy services to Medicare beneficiaries will have to wait until early next year when CMS releases their manual updates. However, it is clear that the potential impact could be dramatic. For a complete initial analysis by LeadingAge NY, please click here.

- ***Multiple Procedure Payment Reduction***

For those providing multiple therapy services on or after April 1, 2013, and for which payment is made under the physician fee schedule, the 25 percent multiple procedure payment reduction (MPPR) is increased to 50 percent.

The floor for the geographic adjustment factors, which are used to modify the relative value of each procedure under the physician fee schedule, has been extended again until January 1, 2014. For more details on the MPPR please refer to Medlearn Matters # 7050.

- ***Physician Quality Reporting System (PQRS)***

CMS continues to use PQRS as a means of promoting quality improvement initiatives and the reporting of quality information by physicians. In the CY 2013 rule, CMS aims to integrate the PQRS reporting requirements with the requirements of the Electronic Prescribing Incentive Program, the Electronic Health Record (EHR) Incentive Program, and the Value-Based Payment Modifier. Moreover, CMS issued a number of changes to facilitate participation. These changes include the following:

1. Expanding the definition of a group practice to include groups of 2-24 eligible providers;
2. Lowering the minimum required number of patient reports in the claims and registry reporting option from 30 to 20; and
3. Including a six-month reporting option in 2013 and 2014 in addition to the 12-month period.

For 2013 the reporting period for PQRS will be based on a 12-month reporting time frame. The bonus payment amount will be .5%. Calendar year 2013 also will be used as the reporting period for the 2015 PQRS payment adjustment of -1.5%. Successful reporting requirements for the program will remain as they were in 2012, requiring that participants report a minimum of 3 individual measures or 1 group measure via claims-based reporting on 50% or more of all eligible Medicare patients, or report a minimum of 3 individual measures or 1 group measure via registry reporting on 80% or more of all eligible Medicare patients.

For purposes of the mandatory physician quality reporting system, CMS shall treat an eligible professional as satisfactorily submitting data on quality measures if the eligible professional is satisfactorily participating in a qualified clinical data registry.

Medlearn Matters # SE0922 gives guidance on how providers can track their quality reporting and electronic prescribing feedback reports from CMS. For more details, you may also refer to the CMS PQRS Web site.

- ***Reminder on CMS Electronic Prescribing Incentive Program***

The Medicare Electronic Prescribing Incentive (eRx) Program for eligible professionals includes a combination of incentive payments and negative payment adjustments related to meeting eRX thresholds. The incentive percentages are one percent of total Medicare Part B payments in 2012 and 0.5 percent in 2013. The eRx program ends after 2014.

On the other hand, the program applies a 1.5 percent downward adjustment in 2013 and a two percent reduction in 2014 to prescribers that fail to meet the minimum threshold. The determination as to whether any payment penalty applies in 2013 is based on electronic prescribing data for the first six months of 2012. The deadline for individual eligible

professionals to submit data to the National Claims History data base is July 26, 2013 in order to avoid payment penalties in 2014.

For complete details, please refer to the CMS MLN Matters # SE1206. This article provides guidance on avoiding negative eRx payment adjustments for individual eligible professionals and selected group practices and the provisions for claiming a hardship exemption.

For our members only, LeadingAge NY also offers a recorded audio conference and slide presentation entitled *Avoiding E-prescribing Penalties*, which is available by clicking here, or refer to our own LeadingAge NY guidance on this topic.

Overpayments

The fiscal cliff legislation extends the period of time during which Medicare contractors can attempt to collect overpayments from providers from three years to five years.

Radiology Services

The legislation limits Medicare payments for stereotactic radiosurgery as part of the complete course of treatment of cranial lesions.

Diabetic Supplies

The legislation establishes new competitive prices for Medicare payment of diabetic supplies and seeks to eliminate overpayments for diabetic supplies.

Ambulance Services

Payments under the ambulance fee schedule for non-emergency transports for end-stage renal disease beneficiaries are reduced by 10 percent for services provided on or after October 1, 2013. The "temporary" increase in the ambulance fee schedule amounts for ground ambulance services originating in a rural or a rural census tract, added in 2004, are extended yet again until January 1, 2014. HHS also is required to prepare a study that analyzes data on existing cost reports for ambulance services furnished by hospitals and critical access hospitals, including variation by characteristics of such providers of services, and another study on the feasibility of obtaining cost data on a periodic basis from all ambulance providers of services and suppliers for potential use in examining the appropriateness of the Medicare add-on payments for ground ambulance services and in preparing for future reform of such payment system.

Advanced Imaging Services

Currently, Medicare payments for advanced diagnostic imaging services are reduced by 75 percent to reflect higher presumed utilization of imaging equipment. Under the legislation, this reduction increases to 90 percent.

Medicare Advantage

The coding adjustment applied to Medicare Advantage (MA) plan adjustments to better align MA payments with Medicare fee-for-service payments is changed from 1.3 to 1.5 percentage points for 2014, and from 5.7 to 5.9 percentage points for 2015 to 2018. The provision allowing specialized MA plans for special needs individuals to restrict enrollment is extended until January 1, 2015. The deadline after which CMS will no longer approve of any new cost plans under MA also has been extended to January 1, 2014.

ESRD Bundled Payments

The legislation requires CMS, for services furnished on or after January 1, 2014, to adjust payments relating to the end stage renal disease (ESRD) bundled payment rate to reflect changes in utilization of certain drugs and biologicals. In making reductions, CMS must take into account

the most recently available data on average sales prices and changes in prices for drugs and biological reflected in the ESRD market basket percentage increase factor. The legislation also delays until January 1, 2016, implementation of oral-only ESRD-related drugs in the ESRD prospective payment system.

HHS also must conduct an analysis by January 1, 2016, of the case mix payment adjustments relating to ESRD bundled payments, and make appropriate revisions to such case mix payment adjustments. The Government Accountability Office (GAO), no later than December 31, 2015, must prepare a report to Congress on how HHS has addressed implementation of payments for oral-only ESRD-related drugs in the bundled ESRD prospective payment system.

Medicare-dependent Hospitals and Low-volume Hospitals

The legislation extends the Medicare-dependent hospital program, which provides extra payments to certain rural hospitals, until October 1, 2013. It also extends through fiscal year 2014 the Medicare adjustment for payments to low-volume hospitals.

Medicaid Changes

The legislation adjusts the calculations for amounts that states receive for disproportionate share hospitals under Medicaid for fiscal years 2021 and 2022. Several programs under Medicaid have been further extended for one year. These include the Qualifying Individual program (through 2013), Transitional Medical Assistance (through 2013), and the "express lane" option for enrollment under both Medicaid and the Children's Health Insurance Program (through 2014).

Additional Changes

In addition, LeadingAge has highlighted the following additional changes in their analysis available by clicking here.

- ***Taxation***

1. As noted above, current tax rates for individuals earning under $400,000 and married couples earning under $450,000 are made permanent; rates for individuals and couples above those income limits raised to 39.6%.

2. Child Tax Credit and Earned Income Tax Credit expanded.

3. Alternative Minimum Tax (AMT) fixed to avoid applying to middle and lower-income workers.

4. Payroll tax cut not extended (this relates to payments into Social Security fund; no changes to Social Security program enacted).

5. Sliding scale reduction of itemized deductions and phase out of personal exemptions for couples with income over $300,000 and individuals with incomes over $250,000. Charitable deductions are not otherwise affected. The Independent Sector has more information.

- ***Impact on Medicare Beneficiaries***

1. There is no change in eligibility (eligibility age not raised to 67; no increase in premiums).

- ***Additional Impact on Providers***

1. There is 1-year extension of Qualifying Individual (QI) program that allows Medicaid to pay Medicare Part B premiums for some low-income beneficiaries.

2. Funding outreach and assistance for Area Agencies on Aging (AAA) and Aging Disability Resource Centers (ADRC) is extended for 1 year.

3. Current funding for Housing and Older Americans Act programs is continued for 2 months, at which time Congress will have to address the funding cuts to domestic and defense programs included in "sequestration" along with the debt limit and other deficit reduction and budget issues.

CLASS Act Repealed

LeadingAge is also closely monitoring developments around the repeal of the CLASS Act and the establishment of a commission to develop a plan for better financing and delivery of long-term care services. The creation of the commission is in line with our advocacy agenda around financing long-term services and supports.

Kicking the Can

A phrase that has become popular in the media lately is "kicking the can down the road", and that is how most political commentators refer to the fiscal cliff deal. In many ways the fundamental issues around the federal budget and the debt ceiling that created the recent crisis remain unresolved and will still need to be addressed over the coming months. This makes the member advocacy of LeadingAge NY and LeadingAge even more important. For legislative alerts from Washington and ways to take action with Congress, please be sure to refer to the LeadingAge advocacy Web site.

Please contact me with any questions at pcucinelli@leadingageny.org or call 518-867-8827.

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